ALDERWOOD VISION THERAPY CENTER, PLLC Drs. Torgerson, Murphy, Maher, Hash, & Schiller

16006 Ash Way, #101, Lynnwood, WA 98087 (425) 787-5200

FAMILY AND SOCIAL HISTORY

Today's Date: _____/______/______

Name: ____________________________ Date of Birth: ______/_______/_______ Age: ________

Health History Update

Since your last visit, have you had any NEW visual or medical problems, new surgeries or hospitalizations? (Include year)

☐ None

____

____

____

____

Medications currently taking and for what condition:

☐ None

____

____

____

____

Allergies:

☐ None

____

____

____

____

Social History ☐ No Changes

Marital Status:

☐ Single ☐ Married ☐ Separated

☐ Divorced ☐ Widowed

Language: ______________________________

Education Completed:

☐ Grade ☐ H.S. ☐ College ☐ Adv. Degree

☐ Other: _______________________________

Employment Status:

☐ Working Occupation: _________________

☐ Unemployed ☐ Retired ☐ Disabled

Family History ☐ No Changes

List you or family member and age diagnosed

Alcoholism ______________________________

Amblyopia ______________________________

Asthma ______________________________

Cancer ______________________________

Color Deficiency______________________________

Diabetes ______________________________

Double Vision______________________________

Glaucoma______________________________

Headaches/Migraines______________________

Heart Disease______________________________

High Blood Pressure______________________

High Cholesterol__________________________

Learning Problems________________________

Macular Degeneration ____________________

Mental Illness (specify) ___________________

Multiple Sclerosis _________________________

Osteoporosis ______________________________

Retinal disease____________________________

Retinitis Pigmentosa_______________________

Strabismus (eye turn) _____________________

Stroke______________________________

Tuberculosis______________________________

Thyroid Condition__________________________

Risk Factors ☐ No Changes

Tobacco: ☐ Never

Year Started: ________ Year Quit: ________

☐ Cigarettes:___ #/day ☐ Cigars:___#/week

☐ Chew:___ cans/day ☐ Pipe

☐ Passive smoke exposure: ☐ Current ☐ Past

Alcohol: ☐ Yes ☐ No

Type: _____________ drinks ____/day

Caffeine: ☐ Yes ☐ No drinks ____/day

Exercise Type: ____________ times ____/week

Recreational Drugs:☐ Yes ☐ No Type: ______

PATIENT OR PARENT/GUARDIAN SIGNATURE: ________________________________

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REVIEW OF SYSTEMS

Today's Date: _____/______/______

Name: ___________________________ Date of Birth: ______/_______/_______ Age: ________

Problems you had in the past/are currently experiencing: ☐ None
☐ No change since previous evaluation

General	Past	Present
Weight loss/gain	☐	☐
Fatigue	☐	☐
Fever or chills	☐	☐
Weakness	☐	☐
Trouble sleeping	☐	☐

Head	Past	Present
Headache	☐	☐
Head Injury	☐	☐
Concussion	☐	☐
Neck pain	☐	☐

Eyes	Past	Present
Vision loss/changes	☐	☐
Pain	☐	☐
Redness	☐	☐
Blurry vision	☐	☐
Double vision	☐	☐
Flashing lights	☐	☐
Specks	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐

Throat, Mouth, Nose, & Ears	Past	Present
Bleeding	☐	☐
Sore tongue	☐	☐
Dry mouth	☐	☐
Sore throat	☐	☐
Hoarseness	☐	☐
Sinus pain	☐	☐
Decreased hearing	☐	☐
Ringing in ears	☐	☐

Respiratory	Past	Present
Cough	☐	☐
Sputum	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐

Cardiovascular	Past	Present
Chest pain/discomfort	☐	☐
Tightness	☐	☐
Palpitations	☐	☐
Shortness of breath	☐	☐
with activity	☐	☐

Gastrointestinal	Past	Present
Swallowing difficulties	☐	☐
Heartburn	☐	☐
Change in appetite	☐	☐
Nausea/vomiting	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐

Musculoskeletal	Past	Present
Muscle or joint pain	☐	☐
Muscle weakness	☐	☐
Trauma	☐	☐

Neurological	Past	Present
Dizziness	☐	☐
Fainting	☐	☐
Seizures	☐	☐
Weakness	☐	☐
Numbness	☐	☐
Tremor	☐	☐

Mental Health	Past	Present
Nervousness	☐	☐
Stress	☐	☐
Depression	☐	☐
Memory loss	☐	☐
Anxiety	☐	☐

Allergy	Past	Present
Persistent infections	☐	☐
Hives	☐	☐
Seasonal Allergies	☐	☐

PATIENT OR PARENT/GUARDIAN SIGNATURE: ___________________________________

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